connective tissue in which the lowest part of the peritoneal cavity dips.

3. At no stage of development is the peritoneum in contact with the prostate, it always being nearer to the rectum than to the prostate.

4. The recto-prostatic space is filled at first with a synticium or mass of embryonic connective tissue cells; eventually differentiation occurs and there is a condensation of connective tissue anteriorly and posteriorly. The anterior layer covering the prostate is the thicker and the elastic tissue fibrils predominate, thereby causing the shiny appearance characteristic of Devonvilliers fascia.

5. A sheath of fascia surrounds the ejaculatory ducts and utricle as they pass through the prostate.

6. The rectourethralis is a sheet of muscle arising from the external longitudinal layer of the rectum and ending in the raphe of the external vesical sphincter.

7. In exposing the prostate by the perineal route the rectourethralis muscle should be cut close to the central tendon, the incision being sufficiently deep to sever the posterior or rectal layer of Devonvilliers fascia, and the dissection continued anteriorly to the muscle, for if the posterior layer is followed it leads directly into the rectum. If the incision is made anterior to the central tendon the dissection leads first into the venous bulb, causing hemorrhage, and then through the external vesical sphincter. The opening of the rectum is avoided, but there is a prolonged and often permanent loss of vesical sphincter control.

8. Long Cowpers ducts ending near the meatus probably develop as periurethral ducts.

(549 Flood Building.)

Resolution on Medical Ethics—"Solicitation of patients by physicians as individuals, or collectively in groups by whatsoever name these may be called, or by institutions or organizations, whether by circulars or advertisements, or by personal communications, is unprofessional. That does not prohibit ethical institutions from a legitimate advertisement of location, physical surroundings and special class—if any—of patients accommodated. It is equally unprofessional to procure patients by indirection through solicitors or agents of any kind, or by indirect advertisement, or by furnishing or inspiring newspaper or magazine comments concerning cases in which the physician has been or is concerned. All other like self-laudations defy the traditions and lower the tone of any profession, and so are intolerable. The most worthy and effective advertisement possible, even for a young physician, and especially with his brother physician, is the establishment of a well-merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of ordinary simple business cards, being a matter of personal taste or local custom, and sometimes of convenience, is not per se improper. As implied, it is unprofessional to disregard local customs and offend recognized ideals in publishing or circulating such cards.

"It is unprofessional to promote radical cures; to boast of cures and secret methods of treatment or remedies; to exhibit certificates of skill or of success in the treatment of disease; or to employ any methods to gain the attention of the public for the purpose of obtaining patients."—Abstract from Minutes of the Seventy-Third Annual Session of the A. M. A.

EARLY HOSPITAL HISTORY IN THE UNITED STATES *

By J. B. CUTTER, M. D., Watsonville, Cal.

With universal interest rapidly growing in all parts of the United States, in the upbuilding and expansion of the modern hospital, the following contribution of historical data about hospitals seems timely.

It is probable that the first hospital in the United States was the Pennsylvania Hospital. There were earlier institutions in Canada and Mexico, and efforts were set on foot as early as 1709 to establish a hospital in Philadelphia. In 1730-31 the City Almshouse was founded, and did medical work, but it was not until 1750-51 that the Pennsylvania Hospital had its actual birth. A history of this hospital was published by Dr. Thomas G. Morton in 1895.

A number of physicians and leading citizens of Philadelphia presented a petition on January 23, 1751, to the Provincial Assembly, praying for authority and assistance to establish an institution for the care of "the insane and indigent sick." Dr. Thomas Bond and Benjamin Franklin seem to have been most active in working up public sentiment, and pushing the matter before the Assembly. The hospital was finally granted a charter by the Governor May 11, 1751. Joshua Crosby was the first president of the Board of Managers and Benjamin Franklin, the first clerk.

The charter of the Pennsylvania Hospital, after providing minutely for the government and management of the proposed institution, appropriated the sum of two thousand pounds to be paid in two annual installments, conditioned on the raising of a like amount through private contributions. Two thousand seven hundred fifty pounds were subscribed within a short time, and the hospital was organized.

The Board of Managers then petitioned Thomas and Richard Penn, who were then living in England, to donate a site for the hospital. This request after considerable correspondence was finally granted, but with so many restrictions that the board resolved not to accept the gift. As the need of the hospital was pressing, a temporary arrangement was entered into by which a private house was rented, and opened for patients February 6, 1762.

Negotiations were kept up with the Penns, which finally led to the purchase from them of part of the present site in 1754, and the remainder of the land was given to the hospital in 1767.

A suitable site having been obtained, plans were drawn and approved and the building begun. The cornerstone was laid May 28, 1755, and the building was so far completed by December 17, 1756, that patients were moved into it on that date from the temporary quarters.

In the meantime the first president, Joshua Crosby, died in June, 1755, and was succeeded by

* Read before the Santa Cruz County Medical Society, at its meeting held in Santa Cruz March 6, 1922.

Benjamin Franklin, who served until his appointment as Provincial Agent at London, in 1757.

This is an outline of the early history, as far as authority can be found, of the first hospital in the United States.

The New York Hospital was the second hospital of importance to be established in the United States. Its charter was granted in 1771.

The history of this second hospital is more clear, and its connection with Trinity church adds to its interest.

There is especial appropriateness in the linking of those two ancient New York institutions, for it was in Trinity church that the hospital was conceived, and through the church influence that it came into being. There is spiritual significance in the association of the church with the divinely appointed mission of a hospital at this early period.

Modern medicine finds in the wisdom of ancient Greece its first great exemplars. Hospitals, as we understand the term, did not exist, but the temples of the gods both in Greece and Italy were the refuge of the sick, and there the priests or family of Aesculapius ministered to those ill of body or mind. In full consciousness, as Walter Pater expresses it, of "the religiousness, the refined and sacred happiness of a life spent in the relieving of pain."

Coming down to modern times, we find that light of the early nineteenth century, Walter Moxon, giving expression to much the same thoughts, "sine missione nascimur," we live to a duty, "It (the hospital) is to be to each individual sufferer under our care, all that a man can be to his fellowman in sickness."

In 1123, St. Bartholomew's of London was founded in the same religious spirit, by private funds donated at the solicitation of Prior Rahere. St. Bartholomew's, organized without ecclesiastic connection, naturally commended itself to the colonies in North America. Other early hospitals in England were: St. Gregory's, founded by Archbishop La Franc in 1084; Holy Cross Hospital, Winchester, 1132; St. Mary's, 1197; and St. Thomas', founded by Peter, Bishop of Winchester, in 1215.

In the year 1769, the colony of New York, with a population of 300,000 of whom only 20,000 lived in the city, had not a single hospital. Medical education in the Colonies was almost as backward. In 1767 a modest beginning had been made in New York by the establishment of a medical department in Kings College, now Columbia University. Two years later, in 1769, the graduating exercises of the first recipients of its medical degrees were, by a happy chance, held within the walls of the original Trinity church. A notable assemblage, including the Governor of the colony, Sir Henry Moore, was present. Lasting distinction was given the occasion by Dr. Samuel Bard, a student of Kings College and the London Hospital, a graduate of medicine of Edinborough University, and professor of the practice of medicine in the college, who after addressing the two graduates on the high duties of their profession, eloquently urged on the community the crying need for a general hospital, not only for the care and relief of the sick but also as affording the best and only means of instructing students properly in the practice of medicine.

This moving appeal met with an immediate response, Sir Henry Moore then and there heading a subscription, and many contributions were received. Sir Henry did not live to see his work crowned, but the hospital was organized in 1770, and on June 13, 1771, in the term of his successor, the Earl of Dunmore, a royal charter was granted to "The Society of the Hospital, in the City of New York."

Steps were immediately taken to procure a site. The city offered a tract of three-quarters of an acre near where the present Municipal building stands. Trinity church which, in 1775, had given Kings College its grounds in Park place, offered the hospital a ninety-nine-year lease of a two-acre plot at Canal and Hudson streets. The society decided to buy a five-acre tract of land on an elevated site on the west side of Broadway, opposite Pearl street. Imposing hospital buildings were painstakingly planned and construction was pressed with all convenient speed. A staff of physicians, including Drs. Bard and Jones, was appointed and preparations for the reception of patients were made. But on the 28th of February, 1775, when the building was practically completed, an accidental fire consumed the interior, and, as the New York Gazette and Weekly Mercury described it, "This beautiful and useful structure, at once the pride and ornament of the city, became a ruin." The Governors made a fresh appeal for funds, four thousand pounds was granted by the Colonial Assembly, reconstruction was begun, and within a year the new hospital building was completed.

During the war of the Revolution, the hospital had a stormy career, and passed into the hands of British and Hessian troops, who used the hospital as barracks and occasionally as a military hospital. When the soldiers were withdrawn and the war ended, a tedious period of readjustment ensued, but not until January, 1791, was it that "this asylum for pain and distress," as the Governors feelingly described it, was finally opened for the treatment of patients.

The original structural group, containing about five hundred beds for patients, continued in active use until 1870, when the Governors of the society found the financial burden of maintaining a hospital on that spacious and valuable site too heavy to bear. They accordingly leased the grounds on long terms, vacated the buildings, and a new hospital was built on the present site, where the work of the society's general hospital has since been conducted.

The need for an emergency service in the lower portion of New York City became so acute that what was long known as the "Chambers Street Hospital" was established in 1875. From that date until 1894, when the modern Emergency Hospital was built, 320,000 patients were treated.

The illustrious names of William T. Bull and

Lewis A. Stimson are forever incorporated into the memorable history of this hospital.

The ambulance service was an important part of the work, which all told aggregated the imposing number of 245,000 calls.

The spirit of noble purpose, devoted and altruistic service which moved our ancestors to create and maintain these wonderful first hospitals, has been repeated in many cities of the United States. Will the modern hospital stand on the same high plane of purpose and achievement?

THE CURABILITY OF SYPHILIS *

By VICTOR G. VECKI, M. D., San Francisco

It is due to animal experimentation that we are able to claim that syphilis is a comparatively easily curable disease and able to hope that it may be abolished. All fixed rules, however, and all schedules must be abandoned. A proper diagnosis must be made, but the benefit of any doubt given to the patient. Every fresh case can and must be aborted. The intensity of the treatment is to be regulated by the patient's bodily condition and his tolerance for the remedies.

Minute care in the preparation of the patient, a faultless technic, heeding of any alarm signals and eventual reactions are absolutely necessary in order to finish intensive treatment without damaging the patient. Each subsequent treatment must be more intensive than the preceding one which failed to cure. Neurosyphilis demands slowly increasing doses, especially small first doses whenever vital parts may be involved. So-called parasyphilitic diseases, mainly tabes dorsalis, yield only to long, regular, persistent and proper treatment. The rhythmic, not the desultory, jerky treatment, accomplishes a cure. The intermittent treatment has failed, it must be abondoned and replaced by the continuous treatment, that is, until a cure is realized.

Recent experiences with the use of very small doses of silver-arsphenamin preparations make the use of mercury less and less imperative; it certainly is not very desirable. Kolle's experiments on animals have demonstrated that mercury is active against the spirochetae only in doses that come very near to the fatal ones.

Neosilver-salvarsan is the best arsenic preparation at our disposal, it is easy of solution, very slow to oxidize and is the most parasitotrop and the least organotrop of all antiluetic remedies. We know that silver itself is an antisyphiliticum, its adding to the arsenic has not increased the toxicity, but only the effectiveness of the remedy. The silver molecule activates the salvarsan molecule. The arsenic being the spirillocide, the silver takes the place of the considerably more toxic mercury to make conditions in the tissues unfavorable for the multiplication of the spirochetae.

There is no real evidence whatever of the dangerousness of the silver-salvarsan preparations. Because of neosilver-salvarsan's low toxicity, the total dose in any given case can be reached quicker and safer and therefore the rhythmic, regular and persistent treatment is possible and our prognosis considerably better. Neurorecidives are never seen, intraspinal injections can be abandoned and replaced by draining of the spinal canal immediately after every third or fourth intravenous injection of neosilver-salvarsan.

The neglecting of proper iodide medication is responsible for many failures in the treatment of syphilis. Iodide is very effective when given intravenously.

The colorimetric reaction of Vernes, when once available everywhere, will enable us to reach periodically a quantitative diagnosis and also to judge when a patient really is cured.

We must positively avoid the dangerous condition created by stopping the treatment when almost all spirochetae are destroyed, and thus giving the few surviving clusters more favorable conditions for their pernicious activities. We agree with Vernes when he preaches that one must do too much in order to do enough.

Syphilis could be abolished when the recognizing of it and its effective treatment will be properly understood by the bulk of the profession, when it will not be considered a vice disease, but just a highly contagious one, and when those in power will understand that the proper fighting of this scourge would be by far cheaper than the support of all the hospitals, asylums, orphanages and prisons, populated by syphilitics and their tainted offspring.

(516 Sutter Street.)

* Abstract of a paper on the Curability of Syphilis read by Dr. Vecki at the Fifty-first Annual Meeting of the Medical Society of the State of California, held in Yosemite National Park, May 15 to 18, 1922.

Arizona State Secretary Visitor at Yosemite Meeting—D. F. Harbridge of Phoenix, Arizona, secretary Arizona State Medical Association, was a visitor at the fifty-first annual meeting of the Medical Society of California. Dr. Harbridge read a paper on "Sympathetic Iridiocyclitis—a Case." The author contributes the case history of a patient, who after having the offending eye removed and his oral cavity made sanitary, recovered a vision 6/15 with a —4D. lens. A detailed pathological study by Finoff of the enucleated eye confirmed the clinical diagnosis. The various theories in explanation of the transference of the inflamation from the sympathogenic to the sympathizing eye, the possible relationship to tuberculosis, the very probable influence of an endogenous infection, and the bearing anaphylaxis may offer as a solution of the problem, is discussed.

Goat Gland Hospital for Ensenada—It is reported in the public press that Ensenada is to have a Goat Gland Hospital. The San Diego Cal., Union says:

"A corps of surgeons, headed by Dr. Benson of Calexico, has leased the Felix Werbser hotel at Ensenada for 15 years and is converting the building into a hospital. Associated with Dr. Benson, it is said, is one of the foremost surgeons of Kansas City. Hundreds of high class goats are to be shipped from San Diego to Ensenada by boat to furnish glands for patients at the new hospital"!!!

Date of 1923 Session—The Board of Trustees of the American Medical Association announces June 25 to 29, 1923, as the dates for the next Annual Session of the American Medical Association at San Francisco.